



**North Carolina Department of Health and Human Services  
Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

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Michael F. Easley, Governor  
Carmen Hooker Odom, Secretary

Michael Moseley, Director

December 22, 2005

**MEMORANDUM**

**To:** Legislative Oversight Committee Members  
Commission for MH/DD/SAS  
Consumer/Family Advisory Committee Chairs  
State Consumer Family Advisory Committee  
Advocacy Organizations and Groups  
North Carolina Association of County Commissioners  
County Managers  
County Board Chairs  
North Carolina Council of Community Programs  
State Facility Directors  
Area Program Directors  
Area Program Board Chairs  
DHHS Division Directors  
Provider Organizations  
MH/DD/SAS Professional Organizations and Groups  
MH/DD/SAS Stakeholder Organizations and Groups  
Other MH/DD/SAS Stakeholders

**From:** Mike Moseley

A handwritten signature in black ink, appearing to be "MM", written over a horizontal line.

A blue rectangular logo with the text "State Plan Communication Bulletin" in white. To the right of the text is a white silhouette of the state of North Carolina.

**Re: Communication Bulletin #051  
Draft Cultural and Linguistic Competency  
Action Plan**

Attached is a draft copy of the Division's Cultural and Linguistic Competency Action Plan. This draft titled "*Cultural and Linguistic Competency Action Plan, Recommendations for Moving from Thought to Practice*" was developed by Division's Cultural Competency Advisory Group (CCAG) which was appointed by me in the fall of 2004. The CCAG was charged with assisting the Division in developing a cultural competency plan for the state operated facilities, Local Management Entities and the provider community. The CCAG held monthly meetings in which it organized, performed research, and received presentations from state experts as well as national experts from the National Center for Cultural Competence resulting in the development of this draft action plan and recommendations.

Please review and offer comments on this draft. The Division will be accepting comments until 5:00 pm on February 3, 2006. Comments may be emailed to Steven Hairston at [Steven.Hairston@ncmail.net](mailto:Steven.Hairston@ncmail.net) or mailed to 3003 Mail Service Center, Raleigh, North Carolina 27699-3003. In order for comments to be considered for inclusion in the final Cultural and Linguistic Competency Action Plan, they must be received by the deadline stated in this Communication Bulletin.

cc: Secretary Carmen Hooker Odom  
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# **Cultural and Linguistic Competency Action Plan**

## **Recommendations for**

### **Moving from Thought to Practice**

**DRAFT**



North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities

and Substance Abuse Services



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## Executive Summary

The past two decades have seen unprecedented demographic shifts nationally and in North Carolina. These shifts have produced significant challenges for health and human service agencies, for local management entities (LME's), providers and the NC Division of MH/DD/SAS. At question is the readiness and preparedness of these agencies to plan for, implement and deliver MH/DD/SA services that are culturally competent, consumer-focused and person-centered to an increasingly diverse consumer community.

Nationally and in North Carolina, cultural and linguistic diversity is a growing challenge for health care delivery systems. In North Carolina, ethnic and minority racial groups represent approximately 30% of the total population. During the last decade, the number of people in need of health care services who have limited English proficiency has risen dramatically. For example, between 1990 and 2000, the Spanish speaking Latino population in North Carolina grew by almost 400%, giving North Carolina the fastest growing Latino population in the country. During this same timeframe the Asian population grew approximately 104%, with African American and American Indian populations experiencing growth of 16.2% and 19.5%, respectively. (1)

Over the past ten years, research reports that highlight disparities among ethnic/racial group consumers have been well documented in areas of education, juvenile justice, health care and MH/DD/SA services. For instance, some of the more important includes the Surgeon General's report issued in 1999 on Mental Health: Culture, Race and Ethnicity, the Office of Civil Rights releases policy guidance for Title VI in 2000 and the Institute of Medicine's (IOM) report on Unequal Treatment in 2002 emphasized the importance of culture for both consumers and providers in the service delivery process.

Furthermore, there is a clear correlation between chronic physical illness and mental illness. According to the supplement to the Surgeon General's Report (2001), chronic physical illness is recognized as a risk factor for mental illness and must be considered within the presence of protective factors such as spirituality, supportive family relationships and availability of health and social services in the community. (2)

The journey towards developing cultural competence within the public mental health, developmental disabilities and substance abuse service system is a dynamic and evolutionary process. The fundamental precepts of cultural competence include developing respect for differences, cultivating successful approaches to diversity, increasing awareness of one's self and of unstated institutional cultural norms and practices and working knowledge of the history, culture, beliefs, values and needs of diverse consumers and communities. A culturally competent approach to services requires that agencies examine and potentially transform each component of mental health, developmental disabilities and substance abuse services, including assessment, treatment, habilitation and evaluation. (3)

In order for service providers to increase their ability to deliver culturally competent services, they must: 1) develop an awareness of their own racial and cultural heritage; 2) understand how cultural heritage influences their biases about normality/abnormality and the process of

service delivery and 3) understand the significant impact that differences, both in language and in verbal and nonverbal styles, have on the process of communication. Moreover, the journey towards cultural competence must be in partnership and collaboration with consumers, families and community members as guides and cultural brokers, not just as passive recipients of services. Cultural brokers are persons who act as a go-between to bridge the gap between the person seeking services and the health care provider. Cultural brokers are a part of the local community of persons seeking services. They help to form the natural, informal and in some cases formal support systems that reform is based upon.

To advise the Division in this endeavor, Director Mike Moseley appointed a 15 member Cultural Competence Advisory Group (CCAG) in the fall of 2004. The CCAG was charged with assisting the Division in developing a cultural competency plan for the Division's state operated facilities, Local Management Entities (LME's) and the provider community. The CCAG held monthly meetings in which it organized, performed research, and received presentations from statewide groups as well as representatives from the National Center for Cultural Competence resulting in the development of this plan and the following recommendations.

### **Recommendations for the Division**

The Cultural Competence Advisory Group makes the following recommendations to the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services for the provision of services that are culturally and linguistically competent for those who seek services from the public system:

1. Continue the Cultural Competence Advisory Group. The group should represent a cross section of the racial and ethnic population of the State. It should have a geographical balance with members representing the eastern, western and central parts of the state and have representation from both urban and rural areas. Members of the group should include consumers and workers in the public MH/DD/SA system. Membership should also include LME Directors or their designated staff who have responsibility for cultural competence or diversity initiatives. The CCAG should continue to advise and offer recommendations to the Division and should be charged with assisting Division staff in planning and executing an annual cultural competency summit/conference.
2. Designate a Division staff person to serve as the Cultural Competency Program Lead. This person would have access to the Director of the Division and have the ability to formulate, with the advice of the Cultural Competency Advisory Group, policy recommendations to the Executive Leadership of the Division.
3. Conduct an external evaluation of MH/DD/SAS, in general specifically related to culturally competent service delivery to diverse consumers. This organizational climate assessment should provide the empirical baseline assessment and accountability model for how the MH/DD/SAS is performing overall in terms of cultural competency at the state, LME, and provider levels with respect to service provision.

4. The Division should establish a statewide report card of accountability based on eight to ten core indicators of success related to culturally competent service delivery to diverse consumers. This report card of selected indicators will provide an empirical baseline for minimum standards related to culturally competent service delivery across all levels of organizational functioning, from executive leadership to clinical management and providers. This baseline assessment would determine the current level of functioning for LME's and providers, furnish the data for comparing current versus future growth and progress, and provide the basis for accountability and resource distribution.
5. Develop a statewide foundational cultural competency training framework that provides building blocks for the Division, LME's and providers to build an effective and flexible cultural competency training model with demonstrated levels of competencies for all MH/DD/SAS providers and stakeholders. This framework and model should be flexible enough for classroom training designs and have the capacity for mental health practitioners and consumers to engage in a self study process on-line ( Level I – (Awareness), Level II – (Knowledge building) and Level -III Skills (Competencies). The framework and model should include evaluations and assessments such that a standard baseline is established for basic content in the areas of awareness, knowledge and skills (competencies). This empirical baseline is critical to maintaining some level of consistency and uniformity in terminology, knowledge, applications and competencies for service delivery across the field of practitioners and consumers statewide.
6. Sponsor a statewide annual cultural competency conference to include citizen experts, managers and leaders of the Division, the Local Management Entities, providers and other public agencies. The purpose of the conference shall be to provide training and information on the delivery of culturally and linguistically competent services and share best practices and networking among providers, consumers and other community stakeholders. LME's will provide reports to the Division regarding the percentage level of effectiveness achieved on designated indicators. The Division will issue a scorecard based upon performance of LME's. The conference will provide the context for providers, consumers, researchers and citizen groups to engage in dialogue and share their successes.
7. The Division should develop an accountability process to ensure that grassroots citizens and consumers are full participants on local and statewide MH/DD/SAS committees, thereby ensuring their involvement in the decision-making process in the development, implementation and evaluation of programs, services and funding to address disparities. The Division and LME's should continue to develop ways to utilize the citizen experts and recruit additional persons to serve as cultural brokers.
8. Develop and provide training in cultural competency for Division staff. The executive leadership and team leaders of the central office and leadership of the state operated facilities should be given first priority to receive this training followed by managers and staff who provide direct services to clients in the facilities. Training for Division personnel is extremely important as these individuals will provide technical assistance,



guidance and oversight for the LME's, providers and consumers regarding the interpretation and implementation of policies and practices, evaluation and assessment of business plans, utilization management plans, and quality assurance.

9. Develop a plan, along with the Citizens Expert group, to have faith-based and community-based organizations play a more significant role in the reform process. The Division and LME's should develop a plan and strategies to: 1) train and hire more ethnic/racial group staff at all levels of the MH/DD/SAS field in order to increase participation of these groups in the service delivery process and 2) develop plans and strategies for fiscal resources to be distributed to indigenous community-based organizations that provide numerous services to underserved populations that may not be easily identified or currently accessing existing MH/DD/SA services.
10. Research, identify and establish the best practices effective in treating culturally diverse consumers. This includes, but is not limited to, research on treatment modalities, support services, medication and residential services. These findings should be communicated to staff, consumers, family members and community leaders as part of training through community education forums.

### **Recommendations for Local Management Entities (LME's)**

1. Conduct an organizational cultural self-assessment. This assessment should provide demographic data on the overall structure and functioning of the LME to include, hiring promotions and staffing positions by ethnic/racial and gender groups. The climate assessment should provide quantitative and qualitative information about how and at what level of effectiveness the agency and its providers currently function, particularly as it relates to diverse consumers.
2. LME's should develop an accountability process to ensure the grassroots citizens and consumers are full participants, on local MH/DD/SAS committees, to ensure their involvement in the decision-making process in the development, implementation and evaluation of programs, services and funding to address disparities. LME's should continue to develop ways to utilize the citizen experts and recruit additional persons to serve as cultural brokers.
3. Develop a community engagement plan for diverse consumers to include: 1) community education forums related to MH/DD/SA issues and stigmas related to receiving services and 2) inclusion and involvement of culturally diverse grassroots consumers (including hearing impaired/hard of hearing) in the decision-making, implementation and evaluation of programs, services and resource allocations. This plan should also include strategies to increase ethnic/racial participation in all staffing areas.
4. Develop and provide on-going training in cultural competency for all staff. Managers and supervisors should be given first priority to receive this training. Training for all personnel is extremely important as these individuals will provide technical assistance, guidance and oversight for providers and consumers regarding the interpretation and

implementation of policies and practices, evaluation and assessment, utilization management plans and quality assurance.

5. Increase capacity to provide customer friendly services to all ethnic/racial groups, particularly those in need of translation and interpretation services, through Spanish/Multilingual (Asian, Hispanic, hearing impaired/hard of hearing) providers and/or interpreters. This includes increasing the numbers of qualified interpreters who also have knowledge and understanding of behavioral health.
6. LME's should develop a plan and process to: 1) Identify culturally appropriate diagnostic tools and the training of staff to utilize the tools, 2) conduct community needs assessments of target ethnic/racial groups consumers and communities, and 3) plan community forums to educate communities on MH/DD/SA issues as well as build networks and community resources to increase utilization of services and make treatment more effective and recovery possible.
7. LME's and their provider communities should develop short term and long range plans to increase ethnic/racial representation through the development of a recruitment strategy to continually recruit, hire and maintain a culturally diverse workforce at all levels of staffing.
8. LME's should engage in culturally specific marketing and public relations engagement strategies. This strategy should be based on community needs assessments that include community forums, focus groups and strategic planning with target communities and consumers in each catchment area. The goal would be to improve and expand community outreach efforts and education to improve perception and reduce, if not eliminate, stigma within the catchment area. These efforts should be utilizing culturally specific knowledge of the ethnic/racial/cultural groups. Whereas some ethnic/racial/cultural groups are very strong in terms of oral traditions, others groups may respond to more traditional mainstream methods. These efforts should also be recovery-focused.

## **Recommendations for Providers**

1. All providers will be expected to review the NC DHHS Cultural and Linguistic Competency Action Plan and document that they have done so. This documentation may be included in the quality assurance auditing measures utilized by the NC Division of MH/DD/SAS.
2. All providers engaged in direct patient care should take an active interest in increasing their cultural competence by attending both mandatory and optional cultural competence education components. Direct community participation in direct clinical services as well as outreach and/or education, is strongly encouraged.
3. As part of the cultural competence curriculum, providers should actively reflect on their biases and beliefs as compared to the cultural majority in the United States. One brief guide can be found online at <http://www.med.umich.edu/multicultural/ccp/assess.htm>.

4. Any provider engaged in clinical care with a patient with Limited English Proficiency not proficient in the client's primary language should utilize appropriate translation services. Use of adult family members as translators should be minimized and use of minors as translators should be prohibited.
5. Providers should be familiar with the basic vocabulary of cultural competence and regularly assess their own level of cultural competence on an informal basis. Some tools for doing so can be found online at <http://www.med.umich.edu/multicultural/ccp/basic.htm#gen>.
6. When engaging in patient care, follow the platinum rule, "Do unto others as they would have done unto them." Providers should make sincere attempts to avoid stereotyping individuals and acting upon cultural generalizations without verifying whether this generalization fits a particular individual. Providers can improve their cross-cultural competence by adopting "clinical pearls" from other clinicians with extensive experiences in working with patients from different cultural backgrounds. One example found online is <http://www.med.umich.edu/multicultural/ccp/approaches.htm#tips>
7. When communicating with clients from a different cultural background, directly or via translator services, providers should utilize well-validated instruments to enhance cultural communication skills. Such tools are available online at <http://www.med.umich.edu/multicultural/ccp/tools.htm>.
8. Providers should view life-long cross-cultural learning as both desirable and clinically necessary.

## Background

On March 31, 2004 under the leadership of Secretary Carmen Hooker Odom, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Office of Minority Health and Health Disparities sponsored a one-day cultural competency workshop. Participants in this one day session included a professional and ethnic cross section of citizen experts representing four racial/ethnic groups (African-American, American Indian, Hispanic/Latino and Asian Islander) from across the state. The morning session, led by Dr. Forrest Toms, a nationally known consultant, focused on defining and understanding cultural competency and the implications for the Division, local management entities (LME's) and their contract providers regarding planning for and implementing culturally competent services to diverse consumers.

The afternoon session involved individual breakout sessions (by ethnic/racial workgroups) moderated by citizen experts, to address a series of brainstorming questions developed to solicit discussion and ideas from the groups. This group of experts set the initial stage for the identification of stigmas to accessing and utilizing services as well as the cultural and linguistic barriers that prevent citizens from seeking services. The citizen experts' critical insight into their communities, their penetrating and thoughtful questions and straight-forward communication brought the needed integrity and openness to begin a dialogue on culturally and linguistically competent MH/DD/SA services.

Common themes identified across the four-racial/ethnic groups:

I. The stigmas, cultural, language and community barriers to accessing services are:

- Those who seek services are perceived as weak and not in control of their lives.
- There was a general fear expressed by each of the groups. The fear consists of being labeled, becoming a social or family outcast, and losing freedom or control of their life once services are sought.
- There is mistrust of the public system. There is the belief that the best interest of the patient is not the first interest of the provider because making money is more important to providers rather than rendering the most appropriate services.
- Barriers to seeking services include fear, lack of local providers, lack of public transportation and other support systems like child and adult daycare.

II. Strategies recommended to the Division and provider organizations to increase awareness of consumers' cultural and linguistic needs include:

### State Division of MH/DD/SAS and state operated facilities

- Better training and education of staff on cultural differences.
- Perform outreach to community to places frequented by community members.
- Recruit and hire staff that mirrors the community.

### Local Management Entities

- Hire staff who are culturally competent and who receive training annually.
- Develop accountability measures and hold staff accountable.
- Perform grass-roots needs assessments and hold community forums to discuss issues in the community.

### Providers

- Offer non-traditional community based services for hard to serve/reach populations.
- Go into the communities and get to know the people who are served.
- Providers need to be held accountable for the manner in which they provide services.

### Community Partners

- Have faith-based and community based organizations play a larger role in reform. They can help to get the message out and provide great places for the distribution of information.
- Actively participate in the development and utilization of information that will be provided to the various communities.
- Assist in identifying sub-populations who may not be visible in traditional systems. (Example, the homeless population).

The overwhelming response to the one day workshop and insightful feedback shared by participants clearly reinforced the importance of and commitment to ensuring that culturally and linguistically competent services be a part of all publicly funded MH/DD/SA programs and services.

To meet this goal, Division Director Mike Moseley initiated a 15 member Cultural Competence Advisory Group. This advisory group consists of a lead staff person from the Division, two members from each of the racial/ethnic groups identified and invited to participate in the March 2004 workshop, a representative from a Local Management Entity, service providers, staff of the Division's state operated facilities and the Office of Minority Health and Health Disparities. Technical assistance and resources were provided by a Division staff member from the Community Policy Section's Prevention and Intervention Team and a consultant that has been working with the Division on its System of Care initiatives. Dr. Forrest Toms is a nationally known expert on cultural competence and diversity issues facilitated the CCAG and performed much of the report writing for the Plan.

The following persons are acknowledged in grateful appreciation of their contributions to the development and/or review, in whole or part, of this report.

### Cultural Competency Advisory Group Members

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|                      |   |
|----------------------|---|
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#### Cultural Competency Advisory Group Staff

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|                |  |
|----------------|--|
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## Introduction

Over the past decade, national and state health and human service agencies have placed a great deal of emphasis on the need for agencies and providers to participate in cultural diversity and cultural competence training. This push for diversity and cultural competence acknowledges the growing understanding and acceptance that cultural and ethnic group differences play a role in the health and human service delivery process. (4)

As the nation's and state's racial and ethnic population continues to grow, group differences can be expected to become more and more of a reality to be understood and respected, particularly by service-based agencies and personnel. The group differences include variations in cultural beliefs, values, behavior styles, health risk indicators and varying levels of choices about how individuals and groups will participate and respond to traditional mainstream American institutional settings and service delivery models. (4, 5)

The challenge will be to understand and respond to these group differences with the potential for these differences to be major sources of strength, rather than sources of tension and differential treatment. It means that health and human service agencies need to find ways to help frontline service providers, frontline supervisors and managers and executive staff increase their knowledge and skills in the areas of culturally competent service delivery. This includes rethinking the effectiveness and efficiency of data collection procedures, program planning and community engagement/outreach strategies, staff development and training and resource utilization. (4, 5)

## Purpose

This document represents the cultural and linguistic competency action plan developed by the Cultural Competency Advisory Group. It continues where the one-day workshop left off. The Cultural Competency Advisory Group identified the need for the delivery of services that are culturally and linguistically competent as paramount to the transformation of the public system. This transformation and the delivery of culturally competent services are driven by federal legislation and policy, changing demographics within the state and a moral consciousness that this is the right thing to do.

Title VI of the Civil Rights Act of 1964 mandates that "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." In 2000, the federal Office of Civil Rights issued policy guidance for Title VI and the United States Department of Health and Human Services' Office of Minority Health published final standards on culturally and linguistically appropriate services (CLAS) in health care.

The Surgeon General's Report issued in 1999 emphasized that states should improve access to quality care that is culturally competent by responding to the needs of ethnic and racial minority populations by implementing standards, thus building trust, increasing awareness and responding to cultural and linguistic differences. This report further documents pervasive disparities in MH/DD/SA care and notes that racially and ethnically diverse groups:



- Are less likely to receive needed MH/DD/SA services and more likely to receive poorer quality of care.
- Are over-represented among the vulnerable populations who have higher rates of mental disorder and more barriers to care.
- Face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health.

The recommendations and content of this action plan are congruent with the Surgeon General's Report on Mental Health and its supplement, "Mental Health: Culture, Race, and Ethnicity" and federal law, such as Title VI of the Civil Rights Act of 1964 and the final report, "Achieving the Promise: Transforming Mental Health Care in America" of The President's New Freedom Commission on Mental Health.

The Cultural Competency Advisory Group, in developing the contents of this action plan, took into consideration reports from many of the nationally recognized experts and organizations on cultural and linguistic competence. The group also reviewed numerous plans from other states to obtain an understanding of the issues that other jurisdictions considered. The Surgeon General's report reinforces the role and importance of culture in the service delivery process. It stated "The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services."

The goal of this action plan is to provide guidance in the form of recommendations to the Division, LME's, providers of services and our partners on the delivery of culturally and linguistically competent services to the citizens of North Carolina who use the publicly funded system of mental health, developmental disabilities and substance abuse services. The Advisory Group is aware that major changes cannot occur overnight. This is a transformation process, like reform itself, but this transformation process must be woven into the fabric of all reform efforts. Cultural and linguistic competency and the delivery of such services should not be seen as an "add on" to service delivery, but should be integrated in the overall fabric of service delivery, linked to quality of care and legitimized by the leaders of the system in policy, practice, procedures and resources.

This action plan is meant to be dynamic and is written to provide flexibility to the Division, LME's, and providers as they develop and implement a service system that is culturally and linguistically competent. The recommendations are organized around six focus areas:

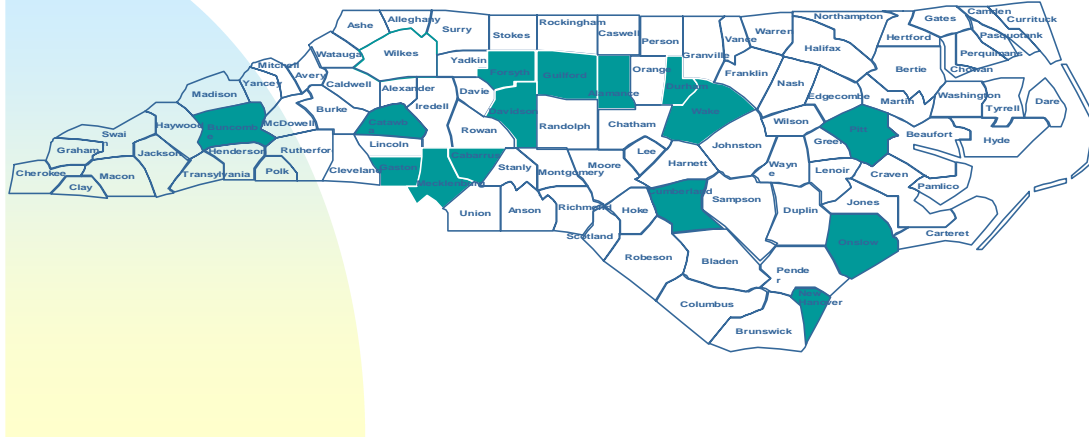
- A system-wide assessment process with standards of measurement around mental health reform, in general, and cultural and linguistic competence, in particular, with the development of a system of accountability in the form of a yearly performance report card,
- Organizational culture and systems change,
- Use of demographic data and quality improvement strategies to improve services,

- Training and Staff development for all stakeholders and development of a core training model that define and set standards for varying levels of competencies to include Level I - Awareness, Level II- Knowledge building and Level -III Skills (Competencies),
- Best practice in service delivery, evidenced based culturally appropriate practice and
- Community engagement, public relations and community partnerships, utilizing citizen experts to serve as cultural brokers with LME's and providers to develop culturally responsive services.

## Why is Cultural Competence Important to North Carolinians?

North Carolina extends east to west for more than 500 miles from the mountainous border with Tennessee to the shores of the Outer Banks. The State comprises a total area of 52,669 square miles including 3,826 square miles of inland water; 20,043,300 acres of forest land; and 3,375 miles of shoreline on the Atlantic Ocean.

### Fifteen Largest Counties in North Carolina by Population, 2000



The 2000 Census reports that North Carolina ranks sixth in the rate of state population growth and is the eleventh largest state with a population of 8,049,313. This includes 6,085,266 people who are 18 years of age or older and 1,964,047 who are younger than 18 years of age.

Data from the 2000 Census show a significant increase in North Carolina's population between 1990 and the year 2000. People of Color, however, experienced higher growth rates between the 1990 census and the 2000 census. As depicted in the table below, the African American population increased by 16%, the Hispanic population by 394% and the Asian-Pacific Islander population by 140%. Today minorities make up about 30% of the state population of 8 million people, compared to only 25% in 1990. Hispanics/Latinos made up about one-fifth of the 1.4 million people added to the state's population from 1990 to 2000 and account for about 5% of the state's population.

The State Demographer within the Office of State Management and Budget estimates the population, as of July 1, 2004, to be 8,634,777. This is an increase of 585,464 or 7.3% since the 2000 census.

| North Carolina  | 2000 Census | 1990 Census | Raw Population Growth | % Growth since 1990 Census | % of Population since 1990 Census |
|---|-------------|-------------|-----------------------|----------------------------|-----------------------------------|
| White   | 5,804,656   | 5,008,491   | 796,165               | 13.7%                      | 70.2%                             |
| African American  | 1,737,545   | 1,456,323   | 281,122               | 16.2%                      | 21.4%                             |
| Native American   | 99,551      | 80,155      | 19,396                | 19.5%                      | 1.2%                              |
| Asian/Pacific Islander  | 113,689     | 52,166      | 61,523                | 140.0%                     | 1.4%                              |
| Hispanic/Latino   | 378,963     | 76,726      | 302,237               | 394.0%                     | 4.7%                              |
| Total   | 8,049,313   | 6,628,637   | 1,420,676             | 17.3%                      | 100.00%                           |
| <p>NOTE: In the 1990 census only one race was reported while in the 2000 census people could report more than one race. The 2000 population data in this table have been "bridged" to single race groups to be more comparable to the 1990 population data and to the single race data from vital records.</p> <p>Data Source: Racial and Ethnic Differences in Health in North Carolina 2004 Update, A Special Report from the State Center for Health Statistics and Office of Minority Health and Health Disparities, p. 9</p> |             |             |                       |                            |                                   |

## Client Population Served

The Division of MH/DD/SAS served 334,856 clients in fiscal year 2004. Of those served, 58% were white. Ethnic/racial group populations represent approximately 41% (35,714) of clients served in 2004 with the largest population being predominantly African American or black (35.4%); 1.4% was American Indians; .3% was Asians. About 2% were Hispanic (.9%, Mexicans; 2% Puerto Rican; 1%, other) (NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, 2004). Based on comparisons with the general youth population of North Carolina, the Division serves a higher percentage of children and youth younger than 18, a lower percentage of whites and a higher percentage of African Americans. The 2000 Census reports the NC population of persons 17 and younger as 24.4% whites as 72% and African Americans as 21.6% (U.S. Census Bureau, 2001).

Consistent with nationwide data (U.S. Department of Health and Human Services, 2001), Hispanics or Latinos and Asians are under-represented among the clients served by the Division. The proportions for these groups are 4.7% for Latinos (whose numbers increased by almost 400% between 1990 and 2000) and 1.4 % for Asians in the NC general population (U.S Census Bureau, 2001). There may be many reasons for variations in minority representation. These may include cultural and socioeconomic issues as well as concerns about stigma or negative attitudes toward people with disabilities. (7)

## **Race and Gender**

Data obtained from initial interviews of the Mental Health and Substance Abuse version of the Division's Client Outcomes Initiative show that more than half (53%) of the population receiving mental health and substance abuse services was male. This was due in part to over-representation of younger males and the over-representation of females among those aged 18 years and older (COI report, 2004). (7)

The most common diagnoses of children served in two System of Care demonstration sites were as follows: attention deficit/hyperactivity disorders (40.7%), oppositional defiant behavior disorders (37.0%), mood disorders (25%), adjustment disorders (17.4%), conduct disorders (12.4%) and post-traumatic stress disorders (10.7%).

Males were two times more likely than females to be diagnosed with ADHD. African American females (39.7%) and White males (39.3%) were diagnosed with oppositional defiant behavior at a slightly higher rate than African American males (34.7%) and White females (34.1%).

About 42.4% of White females were diagnosed with mood disorders. The percentages of African American females, White males and African American males who received a mood disorder diagnosis were 24.6%, 24.3% and 16.4%, respectively. In terms of adjustment disorders, African American females (23.0%) were diagnosed at a slightly higher rate than the other groups. African American males were diagnosed with conduct disorder at a slightly higher rate (17.0%) than African American females and White males and two times more than White females. In addition, about 23% of White females were diagnosed with post-traumatic stress disorder, approximately two times the rate of all other groups. (7)

## **Age**

National statistics indicate that approximately 21% of youth ages 9-17 have a diagnosable mental health condition or an addictive disorder. These disorders range from attention-deficit/hyperactivity, to disruptive disorders, to mood disorders such as depression. Many of these disorders impact daily functioning in such a way that education and academic achievement are impaired.

During the 2003/2004 academic school year, according to the North Carolina Annual School Health Services Report, school nurses provided 36,433 individual health counseling sessions for elementary, middle and high school students. Mental health concerns such as child abuse and neglect, grief and loss, substance abuse, suicide and depression and violence and bullying accounted for 1,189 of those sessions. Of particular importance are suicide attempts and deaths. In the 2003-04 school year, 31 suicidal deaths were reported, compared to eight during the 2002-03 school year. The number of known suicide attempts increased from 431 in 2002-03 to 474 in 2003-04. (8)

In terms of age, youth 12 and older in the System of Care demonstration sites were diagnosed with oppositional defiant disorder (39.6%) and mood disorders (32.1%) more often than were younger children. Conduct disorder (16.0%), adjustment disorder (14.9%) and substance abuse disorders (13.1%) were the next three highest areas of diagnoses for children 12 and older.

For children between 9-11 years of age, oppositional defiant disorders (35.8%), adjustment disorders (20.8%) and mood disorders (19.0%) were the three most frequent diagnoses. Children younger than 8 years of age were diagnosed most frequently with oppositional defiant disorders (28.1%), adjustment disorders (23.6%) and post-traumatic stress disorders (14.8%). (8)

Adults 65 years and older made up another underrepresented segment of the population. With the aging of the baby boomers, individuals in this age range have become an ever-increasing component of the North Carolina MH/DD/SA population. While many are healthy, seniors are generally at greater risk for mental health problems such as anxiety, depression and other mood disorders and alcohol use. Older white males are at greater risk for suicide than the general population. However, only 2 percent of the total number of people served by the Division were 65 years and older (NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, 2004). The 2000 Census estimates the proportion of the population in this age range to be 12% (U.S. Census Bureau, 2001).

The number of seniors in North Carolina has continued to grow rapidly in the last decade reflecting an increase in the general population and greater longevity. In North Carolina in 2000, there were 969,048 adults age 65 or older. This is 12% of the state's residents. These numbers are expected to rise rapidly as "baby boomers" approach retirement. By 2020, the population 65 and older will have grown 71% from the 2002 baseline compared to 36% for the general population. North Carolina's population over age 65 has a lower life expectancy, higher rates of poverty and lower average education and income than their national counterparts. (6)

North Carolina's senior population is not a homogenous group but differs in race, ethnicity, gender, marital status and rurality, all of which are factors that affect their risk for mental health, developmental disabilities and substance abuse problems.

## **Deaf and Hard of Hearing and Deaf-Blind**

North Carolina has provided specialized mental health, developmental disability and substance abuse services to persons who are deaf, hard of hearing and deaf-blind since 1992. In FY03-04, the Area Programs/LME's served 867 persons identifying themselves as deaf, hard of hearing or deaf-blind. (9)

A total of 20 regional clinicians who are sign language fluent and culturally competent provide these specialized services throughout North Carolina. The prevalence rate for persons who are culturally deaf, that is, users of American Sign Language (ASL), are estimated at 0.49% of the general population (National Center for Health Statistics). Based on the 2000 Census, sign language users in North Carolina total approximately 37,500.

The State targets persons who are deaf, hard of hearing or deaf-blind for specialized mental health and substance abuse services. A comprehensive service array for this targeted population has been developed and implemented statewide. While regional clinicians provide the majority of direct services, the State assists local programs with making services language accessible (via interpreters) when necessary.

Specialized services for persons who are deaf, hard of hearing or deaf-blind include an adult inpatient unit at Dix hospital, a six-bed group home in Morganton, four one-bedroom apartments for deaf mentally ill adults in Wilson, and accessible adult care homes in Raleigh and Fayetteville. Further, the Division contracts with the East Carolina University School of Social Work to prepare professionals to work with this targeted population. The Division is committed to the expansion and enhancement of services to this targeted population.

The Division works closely with consumers, advocacy groups, state and county agencies, provider organizations and family members to ensure that services continue to meet current needs. Further, the Division continues its long commitment to working with and listening to the community by assembling the Mental Health Advisory Council for the Deaf and Hard of Hearing each Quarter of the calendar year. (9)

## Language

Cultural and linguistic diversity is a growing challenge for the service delivery system. North Carolina saw the largest increase in the Spanish-speaking Latino population in the United States during the past decade. Approximately half of North Carolina Latinos have limited English proficiency or are unable to speak English well. North Carolina has also become home to a large number of refugees from Vietnam, Laos and other parts of Southeast Asia, many of them boat people who are similarly limited in their ability to access needed services because of language problems (1, 4). Such language barriers can impair ability to access needed programs and services, and many are not knowledgeable about how the US health care system works.

| Faith Action International House (FAIH)   |             |             |                    |
|---|-------------|-------------|--------------------|
| 2002 Hispanic Population Estimates for NC |             |             |                    |
| County                                    | 1990 Census | 2000 Census | FAIH Estimate 2002 |
| Mecklenburg                               | 6,692       | 44,871      | 63,733             |
| Wake                                      | 5,413       | 33,985      | 41,210             |
| Forsyth                                   | 2,102       | 19,577      | 32,000             |
| Guilford                                  | 2,887       | 15,985      | 25,927             |
| Durham                                    | 2,054       | 17,039      | 25,557             |
| Cumberland                                | 13,298      | 20,919      | 23,104             |
| Catawba                                   | 923         | 7,886       | 10,787             |
| Iredell                                   | 692         | 4,182       | 6,641              |



## What is Cultural and Linguistic Competence and How is it Defined?

It is important to note that there is no one definition of cultural competence. Definitions of cultural competence have evolved from diverse perspectives, interests and needs and are incorporated in state legislation, federal statutes and programs, private sector organizations and organizational and academic settings.

North Carolina has adopted a definition that encompasses a very broad spectrum of constituency groups that could require assistance or other supports from an organization, agency or provider as they seek services.

When discussing culture, it is inclusive to all citizens of the state. Culture includes an individual's traits, customs, religion, country of origin, gender, socioeconomic class, sexual orientation, traditions, values, morals, ways and manners of communication. Therefore, a definition originally outlined by Davis (1997) has been modified to state:

*Cultural competence occurs when knowledge, information and data about individuals and groups is integrated and transformed into clinical and best practice standards, skills, service approaches, techniques and marketing programs that match the individual's culture and increase both the quality and appropriateness of {mental health} services and outcomes.*

While this definition is important, the journey toward cultural competence requires that a system of care develop a comprehensive strategy addressing service providers, clinical practices, training, policy, quality assurance and community outreach.

The Cultural Competency Advisory Group believes that to accommodate access and assure an individual's full participation and receipt of maximum benefit from the services offered, the services must be provided in a manner that recognizes and take into consideration the individual's ethnicity, cultural differences, language proficiency, communication and physical limitations. Recognizing and accommodating these differences is cost-effective for the public MH/DD/SAS system, adds customer value to the services provided and is fundamental to customer satisfaction. Staff at all levels of the organization need to be sensitive to and appreciate how important accommodation is to effective service delivery. Creating an atmosphere of staff sensitivity to diversity and recognition of the need for accommodation requires a physical plant (environment) that is designed to be accessible, ongoing staff training, and policies, procedures and practices that promote such sensitivity.

## **Linguistic Competence**

One necessary aspect of cultural competence is linguistic competence and access. Persons with limited English proficiency (LEP) (including those who are deaf or hard of hearing and prefer to use sign language) need to have access to bi-lingual staff or qualified interpreters and translators. A qualified interpreter is sufficiently fluent in both target and source languages so that they are able to accurately interpret to and from either language using any specialized vocabulary needed. The language needs and preferences of persons should be monitored and included in data sets. (10)

North Carolina has adopted a definition that encompasses a very broad spectrum of constituency groups that could require language assistance or other supports from an organization, agency or provider.

It is important that an organization and its personnel communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency and those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of the population served. The organization must have policies, structures, practices, procedures and dedicated resources to support the capacity. This may include, but is not limited to, the use of (10):

- Bilingual/bicultural or multicultural staff;
- Cultural brokers,
- Foreign language interpretation services,
- Sign language interpretation services,
- Multilingual telecommunication systems,
- TTY,
- Assistive technology devices,
- Computer assisted real time (CART) or viable real time transcriptions (VRT),
- Print materials in alternative formats (e.g., audiotape, Braille, enlarged print),
- Varied approaches to share information with individuals who experience cognitive disabilities,
- Materials developed and tested for specific cultural, ethnic and linguistic groups and
- Translation services including those of:
  - Legally binding documents signage,
  - Health education materials and
  - Public awareness materials and campaigns

## **Cultural and Linguistic Values and Principles**

### **What Values and Principles Will We Need To Be Successful?**

Cultural competency is a process based on a set of guiding values and principles. These values and principles must be developed and implemented throughout multiple levels of the organization. The following provides definitions of these guiding values and principles.

#### **Organizational**

- Systems and organizations must sanction and, in some cases, mandate the incorporation of cultural knowledge into policy making, infrastructure and practice.(11)
- Cultural competence embraces the principles of equal access and non-discriminatory practices in service delivery.(11)

#### **Practice & Service Design**

- Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families.(11)
- Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and communities.(11)
- Practice in cultural competent service delivery systems is driven by client preferred choices, not by culturally blind or culturally free interventions.(11)
- Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care.

#### **Community Engagement**

- Cultural competence extends the concept of self-determination to the community.(11)
- Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g. neighborhood, civic and advocacy associations, local/neighborhood merchants and alliance groups, ethnic, social, and religious organizations and spiritual leaders and healers).(11)
- Communities determine their own needs. (12)
- Community members are full partners in decision-making. (12)
- Communities should economically benefit from collaboration. (12)
- Community engagement should result in the reciprocal transfer of knowledge and skills among all collaborators and partners. (12)

## **Family & Consumers**

- Family is defined differently by different cultures.(13)
- Family as defined by each culture is usually the primary system of support and preferred intervention.(13)
- Families and consumers are the ultimate decision makers for services and supports for their children and/or themselves.(13)

## **Culturally and Linguistically Competent Service Delivery: System Change and Capacity Building**

### **System Change**

When systems, organizations and individuals become convinced that change is necessary to conduct business in a new way, they often do not know where to begin. Organizations and employees respond to the forces of change in very different ways. The differences in response to change can be viewed by geographic regions of the country, state, county and neighborhoods and certainly across ethnic, racial and cultural groups. (14) There are any number of approaches that can be followed and an even greater number of change experts that propose different systems of change. However, there seems to be only one truth when it comes to the journey towards cultural competence and that is that there is no one method, no one starting point, no “the way” that fits all individuals and organizations.(4)

Each individual and organization may embark on this journey at different points of departure with different intentions, different strategies for navigating the journey and even different estimated times of arrival. To be sure, most human service organizations and their personnel are at varying levels of awareness, knowledge and competencies along the cultural competency continuum. And, rightly so, achieving organizational and personal cultural competence is a developmental process. (4, 5)

### **Response to Change**

Organizations and employees respond to forces of change in very different ways. From a systems or organizational change perspective, agencies, entities and employees may view the process of change as impersonal because it almost always manifests itself by restructuring how it will operate and function. From an individual perspective, the change process can be threatening because the restructuring itself can create changes in policies, procedures, practices and personnel. (14)

In order for the change process to be implemented, there has to be some level of understanding communicated by leadership, of why any change is necessary and why at this particular chosen time (in the case of North Carolina MH/DD/SAS, that leadership came from the NC Legislature). This process has to come from systematic research or, in the case of MH/DD/SAS, an organizational cultural self assessment of the strengths, weaknesses, internal and external threats affecting the success of the change process. This self-assessment provides the necessary information about the “why” and “what” of change. The assessment is the first of many “building blocks” of *new knowledge acquisition* and understanding of what it will require for the organization and its employees to deliver culturally and linguistically competent services to diverse consumers. Without the “acquisition of new knowledge” and understanding the “why” of change, inertia will prevail and the status quo will be maintained. (14)

## **Assessment Provides the Necessary Information and Opportunities to Build Capacity**

The initial acquisition of information through the organizational self assessment is necessary to enlighten the workforce as to “why” change is necessary and how consumers, the community and the organization will benefit. New knowledge and information are essential to reducing the fear level in any organization. The premise is that “acquiring new knowledge” is necessary for the success of any change efforts. In order for individuals to understand the rationale for change and develop action plans to implement the changes, they must develop new theories related to the needs and the methods whereby change can be accomplished. Without this learning, the commitment to change will be lessened and the anticipated benefits will not be obtained. Thus, neither the organization nor its employees are able to meet the challenges of serving an increasingly diverse consumer population. (5,14)

### **How Can the Entity Assess its Needs?**

The North Carolina Department of Health and Human Services and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services encourage all Local Management Entities, providers and state operated facilities to conduct a cultural self-assessment of attitudes, practices, policies and administrative structure to determine the extent to which the organizations and services delivered are culturally competent. The Division embraces the concept that cultural competence is a developmental process and evolves over an extended period of time. Therefore, conducting a baseline cultural self-assessment will provide insight into the current level of organizational structure and functioning. It is the first step in the cultural competency process.

The ability to participate in self-assessment allows the organization to gauge the degree to which it is effectively addressing the needs of culturally and linguistically diverse groups. The cultural self assessment allows the organization to determine its strengths, weaknesses, areas for growth related to policies, procedures, practices and delivery of services to culturally and linguistically consumers as well as employee staffing and service delivery. The self-assessment should be an on-going process and has the potential to lead to development of a plan with clearly defined short and long term goals, measurable objectives and identified resources.

Upon completion of the self-assessment, the results can be used to develop an organizational plan for achieving and/or enhancing cultural and linguistic competence. These results will provide agencies with the insight into what changes, if any, are needed in terms of organizational vision, mission, values, policies, procedures and general organizational structure and functioning. Results from the assessment should also provide valuable insight into utilization of resources, budgets, and the allocation of fiscal resources, composition of advisory boards and committees and the overall strategic planning processes. The results should provide leaders and leadership teams with working knowledge of staffing patterns, position descriptions and personnel performance measures, approaches to practice, treatment and interventions and delivery of support services.

The assessment should help the organization take a closer look at its quality assurance,

quality improvements, evaluation methods, information management systems and telecommunication systems. Finally, the assessment should help organizations improve their methods and approaches to community engagement, information dissemination with diverse customers and communities and improve their professional development and in-service training activities to insure that personnel are prepared to deliver and sustain culturally relevant service delivery to increasingly diverse consumers and communities.

### **The Cultural Competency Continuum: A Valuable Assessment Tool**

With a better understanding of cultural and linguistic competence and systems change, it is important to understand how these values and principles translate into measurable competencies. These measurable competencies provide the “building blocks,” guidelines and standards, when executed properly, for the development of a cultural competency plan, the implementation of the plan and the management, assessment and on-going monitoring. With the knowledge that change, in terms of cultural competency, must be viewed organizationally and individually, it is imperative to understand the parameters of competencies on the continuum of change.

The cultural competency continuum is a valuable resource and tool for assessing and monitoring an organization’s current status, progress and areas in need of change and improvement.

Cultural competency should be viewed in terms of a continuous progression of growth, development and change. Organizations should think of it as the building block of the change process. As with anything that is under construction, there must be a starting point. Thus, the cultural competence continuum for organizations and individuals should reflect a specific starting point to begin building their competencies to provide services to diverse consumers.

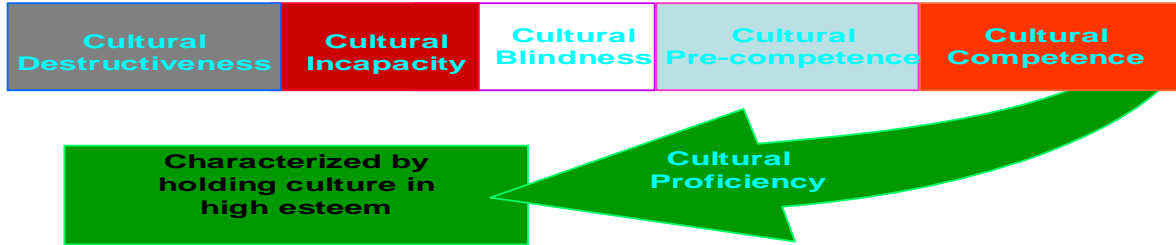
Mason outlined a cultural competence model in which individuals’ transition from damaging and miseducative practices to professional practices that endorse culturally relevant service delivery models (15). This model consists of five stages or statuses, which include:

1. Cultural Destructiveness,
2. Cultural Incapacity,
3. Cultural Blindness,
4. Cultural Pre-competence and
5. Cultural Competence.

From a macro-cultural perspective, organizations adopt policies and practices oriented toward or away from cultural competence. From an individual or micro-cultural perspective, representatives of an agency enact the values and viewpoints of that particular organization (the values, viewpoints and belief systems of the geographical area and/or communities in which they live).

# Culturally Competent Delivery System

## Cultural Competence Continuum



Cross et al (1989).

### Cultural Destructiveness

*Cultural destructiveness* is the stage at which individuals and groups refuse to acknowledge the presence or importance of cultural differences in the service delivery process. In addition, any perceived or real differences from dominant mainstream culture are punished and suppressed. Institutions and individuals in this stage tend to endorse the myth of universality, insisting that all children conform to a mainstream middle-class imperative. Given this stage, there is often a disregard for diverse consumers' cultures of origin in favor of the values and viewpoints of the dominant culture. This orientation refuses to consider that service providers must respond to consumers within a particular cultural context.

### Cultural Incapacity

*Cultural incapacity* refers to the stage in which cultural differences are neither punished nor supported. This occurs when the individual or organization chooses to ignore differences. Here, no attention, time, training or resources are devoted to understanding and supporting cultural differences. Often providers and institutions remain oblivious to the proportional importance of cultural competence. More attention may be devoted to diagnosis without considerations of cultural issues embedded in the clinical approach. During this stage, limited efforts are made to capitalize on the rich cultural resources consumers bring.

### Cultural Blindness

*Cultural blindness* represents the stage when the individual or organization actively proffers the notion that cultural differences are inconsequential and, as such, of no importance. Cultural differences may be noted but being color-blind (and culture-blind) is



the desired state. No resources, attention, time or training are devoted to understanding cultural differences. Often providers and organizations operating in this stage develop their understanding of consumers from culturally different backgrounds using a race or cultural neutral lens. Although some individuals see this approach as a tool for appearing bias-free, such a strategy often denies an important aspect of who a consumer is and how that identity impacts his/her decision making and beliefs about the world.

### **Cultural Pre-competence**

During the *cultural pre-competence* stage, providers and organizations recognize and respond to cultural differences and attempt to correct non-liberating and unethical structures, service delivery practices, and inequities. Openly acknowledging the need for cultural competency is an initial step toward destroying some of the debilitating practices that limit the access and service delivery to culturally diverse consumers. Openly acknowledging the need for cultural competency is an initial step toward destroying some of the debilitating practices that limit mental wellness of culturally diverse consumers. Providers and organizations performing at this stage may seek out new information about diversity by attending training sessions and/or interacting with individuals who have insider cultural information.

### **Cultural Competence**

Finally, *cultural competence* is at the opposite extreme of the cultural destructiveness stage. Organizations and individuals learn to value cultural differences and attempt to find ways to celebrate, encourage, and respond to differences within and among themselves. When providers, organizations and communities are actively exploring issues of equity, cultural history and knowledge, social justice, privilege and power relations, they are at a stage of cultural competence. Moreover, when organizations, providers and communities are culturally competent, they recognize the culture of consumers as a resource for providers, the consumers themselves, their families and the community. As providers consider the issues that affect consumer lives, as well as the cultural areas in this stage, there is a commitment to initiating structural changes that ensure culturally specific, responsive and relevant services.

## **How Does the Cultural Competency Continuum Apply to My Agency?**

When organizations and individuals become convinced that change is necessary to conduct business in a new way, they often do not know where to begin. There are a number of approaches that can be followed and an even greater number of change experts that propose different systems of change.

The Division, LME's and Providers should use the Cultural Competency Continuum as a baseline for assessing where individuals and organizations are in terms of their readiness, preparedness and current level of functioning.

In terms of starting points for change, it will not be beneficial for individuals or agencies to over-estimate their capacity to deliver culturally competent services. Likewise, it would not be wise or professionally appropriate to underestimate the challenges of preparing an agency and its personnel to become competent and proficient in negotiating across cultures in terms of service delivery.

The Division understands that it will take agencies and providers a reasonable amount of time to actually become culturally competent in providing services to diverse groups, so it would expect to see low ratings in various areas early in the process and would encourage the development of a 2-3 year organizational plan to reflect how those areas will be addressed and improved.

The Division understands and expects that individuals and organizations will be at different points of competency on the cultural competency continuum. Thus, agencies and individual providers in an agency can be operating at different levels on the cultural competency continuum with consumers from different ethnic/racial cultural groups and/or communities. An agency could be at a cultural competence level with African Americans and at a cultural blindness level with Hmong clients. Therefore, in developing a cultural competence assessment and plan, the agency must be realistic about the consumers served, how well they are served and how the cultural competency of staff will vary with different cultural groups.

*The following are examples of possible organizational challenges agencies will encounter in their initial attempts to assess their level of cultural competence throughout the agency and in the community.*

**Example # 1**

**An Organization at Administrative Pre-competence Stage and Cultural Blindness or Cultural Incapacity Stage as it relates to Service Delivery**

An LME may have started by holding several meetings with its leadership team and providers to establish Cultural Competency Teams and by sending out written communications to consumers regarding the agency's commitment to consumer choice and diversity. The LME has established organizational cultural competency teams (an internal team of leadership and personnel and an external team consisting of LME leaders, providers and consumers). The LME from an organizational perspective would be at a Pre-competence level on the cultural competency continuum. However, clinical directors, therapists and other front-line employees of the agency may still be operating at a Cultural Incapacity or Cultural Blindness Level as they may continue to practice service delivery that is not culturally sensitive or delivered in the consumer's primary language.

**Example # 2**

**An Organization at a Cultural Blindness and Cultural Incapacity Stage**

An LME has not started any efforts to begin addressing Cultural Competence. The leadership has yet to develop a plan and process for the leadership team to formulate an organizational cultural competency team. The organization, in the midst of all the other changes and challenges, feels that they treat all consumers and employees the same. So, at this time no attention, time or resources have been put in place to address issues related to cultural competency.

## How Do We Get Started?

Convene a cultural competence committee or task force within the organization. This committee should have representation from policy making, administration, practice/service delivery and consumer levels. The committee can serve as the primary governing body for planning, implementation and evaluating organizational cultural competence initiatives. There are some organizations that have enlisted the services of consultants and/or technical assistance with well established and proven individuals and companies. Other agencies have started their initiatives and brought in different expertise later to provide assistance.

- Ensure that the organization has a mission statement that commits to cultural competence as an integral component of all activities. The cultural competence committee should be involved in developing this statement.
- Network and dialogue with similar organizations that have begun the journey toward developing and implementing culturally competent service delivery systems. Adapt processes and information that are consistent with your organization's needs and interest.
- Conduct a comprehensive cultural competence agency self assessment. This should be one of the first responsibilities of the cultural competence committee, along with the development of a mission statement and a statement of organizational values for cultural competence. The committee should research various self assessment tools that provide insight into organizational structure and functioning, clinical practices, human resources, service delivery, community relationships and staff development. Use the results to develop a long-term plan, with measurable goals, objectives, and timelines to incorporate into all aspects of the organization. This may include, but is not limited to, changes in the following: mission statement, policies, procedures, practices, administration, staffing patterns, service delivery practices and approaches, community outreach, telecommunications, information dissemination and professional development activities.
- Determine the culturally, linguistically, racially and ethnically diverse groups within the catchment area served by your organization. Assess the degree to which these groups are accessing services and the level of satisfaction with services received.
- Conduct an assessment of what organization personnel perceive as their staff development needs related to the provision of services to culturally and linguistically diverse ethnic/racial/cultural groups.
- Convene informal brown bag lunches to engage personnel in discussions and activities that offer an opportunity to explore attitudes, beliefs and values related to cultural diversity and cultural competence. Unless the organization has a person(s) that specializes in this area, it would probably be better to solicit an outside consultant or technical assistance. This should also be an area that the cultural competence

committee develops a plan of action to address.

- Identify and include budgetary expenditures each fiscal year to facilitate personnel development through their participation in conferences, workshops and seminars on cultural competence.
- Gather and organize resource materials related to mental health and culturally diverse groups for use by organizational personnel.
- Build and utilize a network of natural helpers, community informants and other “brokers” or “experts” who have knowledge of cultural, linguistic, and ethnic/racial groups served in your catchment area.
- Network with parents, family organizations, minority businesses, faith-based institutions and other community based groups to build relationships and educate them about your organizations services and willingness to be a part of the community.

## Recommendations

### Recommendations for the Division

The Cultural Competence Advisory Group makes the following recommendations to the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to provide for the provision of services that are culturally and linguistically competent for those who seek services from the public system.

1. Continue the Cultural Competence Advisory Group. The group should represent a cross section of the racial and ethnic population of the State. It should have a geographical balance with members representing the eastern, western and central parts of the state and have representation from both urban and rural areas. Members of the group should include consumers and workers in the public MH/DD/SA system. Membership should also include LME Directors or their designated staff who have responsibility for cultural competence or diversity initiatives. The CCAG should continue to advise and offer recommendations to the Division and should be charged with assisting Division staff in planning and executing an annual cultural competency summit/conference.
2. Designate a Division staff person to serve as the Cultural Competency Program Lead. This person would have access to the Director of the Division and have the ability to formulate, with the advice of the Cultural Competency Advisory Group, policy recommendations to the Executive Leadership of the Division.
3. Conduct an external evaluation of MH/DD/SAS, in general specifically related to culturally competent service delivery to diverse consumers. This organizational climate assessment should provide the empirical baseline assessment and accountability model for how the MH/DD/SAS is performing overall in terms of cultural competency at the state, LME, and provider levels with respect to service provision.
4. The Division should establish a statewide report card of accountability based on eight to ten core indicators of success related to culturally competent service delivery to diverse consumers. This report card of selected indicators will provide an empirical baseline for minimum standards related to culturally competent service delivery across all levels of organizational functioning, from executive leadership to clinical management and providers. This baseline assessment would determine the current level of functioning for LME's and providers, furnish the data for comparing current versus future growth and progress, and provide the basis for accountability and resource distribution.
5. Develop a statewide foundational cultural competency training framework that provides building blocks for the Division, LME's and providers to build an effective and flexible cultural competency training model with demonstrated levels of competencies for all MH/DD/SAS providers and stakeholders. This framework and model should be flexible enough for classroom training designs and have the capacity for mental health practitioners and consumers to engage in a self study process on-line ( Level I –

(Awareness), Level II – (Knowledge building) and Level -III Skills (Competencies).

The framework and model should include evaluations and assessments such that a standard baseline is established for basic content in the areas of awareness, knowledge and skills (competencies). This empirical baseline is critical to maintaining some level of consistency and uniformity in terminology, knowledge, applications and competencies for service delivery across the field of practitioners and consumers statewide.

6. Sponsor a statewide annual cultural competency conference to include citizen experts, managers and leaders of the Division, the Local Management Entities, providers and other public agencies. The purpose of the conference shall be to provide training and information on the delivery of culturally and linguistically competent services and share best practices and networking among providers, consumers and other community stakeholders. LME's will provide reports to the Division regarding the percentage level of effectiveness achieved on designated indicators. The Division will issue a scorecard based upon performance of LME's. The conference will provide the context for providers, consumers, researchers and citizen groups to engage in dialogue and share their successes.
7. The Division should develop an accountability process to ensure that grassroots citizens and consumers are full participants on local and statewide MH/DD/SAS committees, thereby ensuring their involvement in the decision-making process in the development, implementation and evaluation of programs, services and funding to address disparities. The Division and LME's should continue to develop ways to utilize the citizen experts and recruit additional persons to serve as cultural brokers. Cultural brokers are persons who act as a go-between to bridge the gap between the person seeking services and the health care provider. Cultural brokers are a part of the local community of persons seeking services. They help to form the natural, informal and in some cases formal support systems that reform is based upon.
8. Develop and provide training in cultural competency for Division staff. The executive leadership and team leaders of the central office and leadership of the state operated facilities should be given first priority to receive this training followed by managers and staff who provide direct services to clients in the facilities. Training for Division personnel is extremely important as these individuals will provide technical assistance, guidance and oversight for the LME's, providers and consumers regarding the interpretation and implementation of policies and practices, evaluation and assessment of business plans, utilization management plans, and quality assurance.

9. Develop a plan, along with the Citizens Expert group, to have faith-based and community-based organizations play a more significant role in the reform process. The Division and LME's should develop a plan and strategies to: 1) train and hire more ethnic/racial group staff at all levels of the MH/DD/SAS field in order to increase participation of these groups in the service delivery process and 2) develop plans and strategies for fiscal resources to be distributed to indigenous community-based organizations that provide numerous services to underserved populations that may not be easily identified or currently accessing existing MH/DD/SA services.
10. Research, identify and establish the best practices effective in treating culturally diverse consumers. This includes, but is not limited to, research on treatment modalities, support services, medication and residential services. These findings should be communicated to staff, consumers, family members and community leaders as part of training through community education forums.



## Recommendations for Local Management Entities (LME's)

1. Conduct an organizational cultural self-assessment. This assessment should provide demographic data on the overall structure and functioning of the LME to include, hiring promotions and staffing positions by ethnic/racial and gender groups. The climate assessment should provide quantitative and qualitative information about how and at what level of effectiveness the agency and its providers currently function, particularly as it relates to diverse consumers.
2. LME's should develop an accountability process to ensure the grassroots citizens and consumers are full participants, on local MH/DD/SAS committees, to ensure their involvement in the decision-making process in the development, implementation and evaluation of programs, services and funding to address disparities. LME's should continue to develop ways to utilize the citizen experts and recruit additional persons to serve as cultural brokers.
3. Develop a community engagement plan for diverse consumers to include: 1) community education forums related to MH/DD/SA issues and stigmas related to receiving services and 2) inclusion and involvement of culturally diverse grassroots consumers (including hearing impaired/hard of hearing) in the decision-making, implementation and evaluation of programs, services and resource allocations. This plan should also include strategies to increase ethnic/racial participation in all staffing areas.
4. Develop and provide on-going training in cultural competency for all staff. Managers and supervisors should be given first priority to receive this training. Training for all personnel is extremely important as these individuals will provide technical assistance, guidance and oversight for providers and consumers regarding the interpretation and implementation of policies and practices, evaluation and assessment, utilization management plans and quality assurance.
5. Increase capacity to provide customer friendly services to all ethnic/racial groups, particularly those in need of translation and interpretation services, through Spanish/Multilingual (Asian, Hispanic, hearing impaired/hard of hearing) providers and/or interpreters. This includes increasing the numbers of qualified interpreters who also have knowledge and understanding of behavioral health.
6. LME's should develop a plan and process to: 1) Identify culturally appropriate diagnostic tools and the training of staff to utilize the tools, 2) conduct community needs assessments of target ethnic/racial groups consumers and communities, and 3) plan community forums to educate communities on MH/DD/SA issues as well as build networks and community resources to increase utilization of services and make treatment more effective and recovery possible.

7. LME's and their provider communities should develop short term and long range plans to increase ethnic/racial representation through the development of a recruitment strategy to continually recruit, hire and maintain a culturally diverse workforce at all levels of staffing.
8. LME's should engage in culturally specific marketing and public relations engagement strategies. This strategy should be based on community needs assessments that include community forums, focus groups and strategic planning with target communities and consumers in each catchment area. The goal would be to improve and expand community outreach efforts and education to improve perception and reduce, if not eliminate, stigma within the catchment area. These efforts should be utilizing culturally specific knowledge of the ethnic/racial/cultural groups. Whereas some ethnic/racial/cultural groups are very strong in terms of oral traditions, others groups may respond to more traditional mainstream methods. These efforts should also be recovery-focused.

## Recommendations for Providers

1. All providers will be expected to review the NC DHHS Cultural and Linguistic Competency Action Plan and document that they have done so. This documentation may be included in the quality assurance auditing measures utilized by the NC Division of MH/DD/SAS.
2. All providers engaged in direct patient care should take an active interest in increasing their cultural competence by attending both mandatory and optional cultural competence education components. Direct community participation in direct clinical services as well as outreach and/or education, is strongly encouraged.
3. As part of the cultural competence curriculum, providers should actively reflect on their biases and beliefs as compared to the majority United States culture. One brief guide can be found online at <http://www.med.umich.edu/multicultural/ccp/assess.htm>.
4. Any provider engaged in clinical care with a patient with Limited English Proficiency not proficient in the client's primary language should utilize appropriate translation services. Use of adult family members as translators should be minimized and use of minors as translators should be prohibited.
5. Providers should be familiar with the basic vocabulary of cultural competence and regularly assess their own level of cultural competence on an informal basis. Some tools for doing so can be found online at <http://www.med.umich.edu/multicultural/ccp/basic.htm#gen>.
6. When engaging in patient care, follow the platinum rule, "Do unto others as they would have done unto them." Providers should make sincere attempts to avoid stereotyping individuals and acting upon cultural generalizations without verifying whether this generalization fits a particular individual. Providers can improve their cross-cultural competence by adopting "clinical pearls" from other clinicians with extensive experiences in working with patients from different cultural backgrounds. One example found online is <http://www.med.umich.edu/multicultural/ccp/approaches.htm#tips>.
7. When communicating with clients from a different cultural background, directly or via translator services, providers should utilize well-validated instruments to enhance cultural communication skills. Such tools are available online at <http://www.med.umich.edu/multicultural/ccp/tools.htm>.
8. Providers should view life-long cross-cultural learning as both desirable and clinically necessary.

## **ATTACHMENT A**

### **Findings from the Citizen Groups that attended the Division's Cultural Competence Conference on March 31, 2004.**

Individual group themes identified and reported include:

#### **I. AFRICAN-AMERICANS**

##### **A. Brain Storming**

1. What are some of the stigmas associated with accessing and utilizing MH/DD/SA services for the African American community?
  - a. People who receive services cannot control their lives; seen as weak.
  - b. Fear of being labeled.
  - c. Mistrust of the system.
  - d. Fear that information provided will not be kept confidential.
  - e. African-Americans do not typically access and utilize MH/DD/SA services.
  - f. Denial that a problem exists prevents seeking services.
2. What are some of the cultural, linguistic, community and systemic barriers to accessing MH/DD/SA services for African Americans in North Carolina?
  - a. Lack of trust in the MH/DD/SAS system.
  - b. Providers of services are not located in the community.
  - c. Providers are not accessible.
  - d. Lack of transportation prevents one from obtaining services.
  - e. Racist attitudes prevent proper care from being provided.
  - f. Denial that a problem exists.
  - g. Lack of access to MH/DD/SAS system.
  - h. Misdiagnosis of the actual problem.

##### **B. Awareness**

1. What strategies would you recommend to each of the following entities to increase their awareness of consumers' cultural and linguistic needs?
  - a. State DMH/DD/SAS
    - Develop a way to collect data on consumer needs.
    - Training and education for staff.
    - Convening focus groups and follow-up on results.
    - Allow LMEs to use creative policies to assist clients.
  - b. Local Management Entities (LMEs)
    - Provide training and education for LME staff.
    - Hold community forums.
    - Perform a grassroots needs assessment.

- c. Providers
  - Create a mechanism to receive feedback that allows clients to provide information about their care experience without fear of retribution.
  - Pay attention and be proactive about asking clients about their needs as they transition between levels of care.
  - Immediate statewide recruitment efforts for qualified African Americans.
- d. Partners
  - Have church and faith-based organizations understand their role in the African American Community.
  - Help to identify sub-populations that may not be visible to traditional systems.
  - Involve these groups in helping to provide information to patients and families.

### **C. Skills Development**

1. What are the characteristics (personal attributes, knowledge and skills) of service providers that are necessary to address consumer's cultural and linguistic needs?
  - a. Listening skills.
  - b. An understanding of what makes cultures different.
  - c. An understanding or knowledge of why African Americans may not trust health care providers.
  - d. The ability to listen and to be open-minded and not judgmental.
  - e. Cultural sensitivity.
  - f. Willingness to collaborate to maximize limited resources.
  - g. Respectful of people at every level.
2. How would you improve the characteristics for this group to address consumers' cultural and linguistic needs?
  - a. State MH/DD/SAS
    - Learn from more progressive state agencies how they have enhanced cultural competence.
    - Develop a way to collect data on consumer needs.
  - b. Local Management Entities (LMEs)
    - LMEs need to be able to understand the value of data, obtain training to be able to interpret data and examine data to make sure that provider performance is consistent.
    - Communicate better and have open lines of communication.
    - Have written communication in Spanish and English.

c. Providers

- Learn the difference between apathy, sympathy, and empathy.
- Awareness of scientific evidence of discrimination.
- Continuing education on cultural competence.

**D. Recruitment (Staff & Provider Networks)**

1. What strategies need to be in place at the state and local levels to hold LME's accountable for the recruitment and retention of a diverse workforce?
  - a. Use incentives to hire minorities.
  - b. Education reimbursement.
  - c. Establish incentives for employees to work in rural areas.
  - d. Recruit in colleges and offer scholarships for graduate school.
2. What strategies need to be in place at the academic institutions as well as in the employment organizations to ensure recruitment and retention of a diverse MH/DD/SAS workforce?
  - a. Create an environment conducive to learning.
  - b. Create a value for non-traditional work settings and experiences through regional training that will later be used to [can't read writing] certification.
  - c. Invite great lecturers who are working the field and who are practitioners.

**E. Outreach Strategies**

**Consumer and Family Advisory Committee (CFAC)**

1. What strategies would you recommend to ensure representative membership on CFACs based on the racial/ethnic make-up of the community served?
  - a. Find and use Peer Opinion Leaders.
  - b. Go to where African Americans are located.
  - c. Solicit community advocacy groups for members.
  - d. Seek out owners of minority community-based programs.
2. What are some accountability measures that can be used by the state agency and LMEs to select CFACs?
  - a. Public local CFAC reports.
  - b. Develop and publish outcome measures.
3. What should be the guideline/criteria for selecting CFAC members?
4. How can state, LME, and provider networks increase outreach to African American underserved populations?

**F. Public Information/Communication**

1. Which media are effective in delivering health-related information to the African-American communities (i.e. radio, TV, newspaper, word of mouth, flyers, church bulletins etc.)?
2. For written materials, what is the recommended reading level?

**G. Assessments**

1. How to ensure that assessments and person centered plans address the cultural and linguistic needs of consumers and the diversity within racial/ethnic groups?

## **II. AMERICAN INDIAN (AI)**

### **A. Brain Storming**

1. What are some of the stigmas associated with accessing and utilizing MH/DD/SA services for the American Indians (AI) community?
  - Responses given from the group would indicate that pride; embarrassment and denial would all be important reasons why they would not access services. They also indicated that there is not much of a trust in the system itself which would prevent services from being sought.
2. What are some of the cultural, linguistic, community and systemic barriers to accessing MH/DD/SAS for AI's in North Carolina?
  - The group felt very strongly that the workforce should represent their culture and that it does not. This hinders them from accessing services. They also felt that the system does not know them as a people. Therefore, they do not feel they are welcomed into the system. The other concern seemed to be a lack of resources, although that was not the driving force.

### **B. Awareness**

What strategies would you recommend to this group to increase their awareness of consumers' cultural and linguistic needs?

1. State DMH/DD/SAS
  - Allow the Indian Commission to be the LME for the AI. Take time to get to know the AIs and their history, more meetings and public forums. Let AI service AI.
2. Local management entities (LMEs)
  - Let Indian Commission be LME for AI with LME governing funding, open meetings, and empowerment. Be culturally sensitive to AI.
3. Providers
  - Must value the visit of the AI, go to the community and get to know the people, Cultural Awareness Training. Know who you are when you are with AI and be ok with who you are.
4. Partners
  - Increase cultural awareness, communication among groups, education of services and awareness.



## **C. Skills Development**

1. What are the characteristics (personal attributes, knowledge and skills) of service providers necessary to address consumers' cultural and linguistic needs?
  - Must have respect for the people they are serving, must be compassionate and want to have meaningful communication, must get to know the AIs, the different tribes, and their culture.
2. How would you improve the characteristics for this group to address consumers' cultural and linguistic needs?
  - a. State MH/DD/SAS
    - Workgroup thought respect was critical and reiterated what was said in 1.
  - b. Local management entities
    - Workgroup thought respect was critical and reiterated what was said in 1.
  - c. Providers
    - Workgroup thought respect was critical and reiterated what was said in 1.
  - d. Partners
    - Workgroup thought respect was critical and reiterated what was said in 1

## **D. Recruitment (Staff & Provider Networks)**

1. What strategies need to be in place at the state and local levels to hold LMEs accountable for the recruitment and retention of a diverse workforce?
  - Establish a Mentor and Intern Program for AI, training and incentives for recruitment and retention, increase awareness of AI.
2. What strategies need to be in place at the academic institutions as well as in the employment organizations to ensure recruitment and retention of a diverse MH/DD/SAS workforce?
  - Increase awareness to AI of what is available and how to cause it to happen.

## **E. Outreach Strategies**

1. Consumer and Family Advisory Committees (CFACs)
  - a. What strategies would you recommend to ensure representative membership to CFACs based on the racial/ethnic make-up of the community served?
    - Committee must be representative of people, needs to have committee that crosses over disabilities (not just have one disability type on CFAC), needs to look and grassroots of people (what is their history, where do they come from), includes as part of the Performance Agreement that the committee have AI representation, they need to network with AI.
  - b. What are some accountability measures that can be used by the state agency and LMEs to select CFAC members?
    - Look at what the standard says and follow it.
  - c. What should be the guideline/criteria for selecting CFAC members?
    - See 1 and 2 for answer

- d. How can state, LME, and provider networks increase outreach to underserved American Indians and other populations?
  - By first wanting to reach out to them, then by going into the communities and getting to know the people

## **F. Public Information/Communication**

1. Which media are effective in delivering health-related information to the American Indian communities (i.e. radio, TV, newspaper, word of mouth, flyers, church bulletins etc.)?
  - The workgroup did not feel that written material would be a good way to get information out. They felt that word of mouth at local hangouts, fairs, churches, sports events and at annual Homecoming was the best way, in a culturally relevant way.
2. For written materials, what is the recommended reading level?
  - They did not feel this was a good way.

## **G. Assessments**

1. How to ensure that assessments and person-centered plans address the cultural and linguistic needs of consumers and the diversity within racial/ethnic groups?
  - The workgroup felt very strongly that this should be an on-going process and not just a one time thing. They felt questions should be geared to who they are and that questions should be specific to engage conversation and not just yes/no. They felt that to get the best response, the assessment should be conducted in the home and community and that assessments should be specific to the culture and language needs.

### **III. ASIAN /PACIFIC ISLANDER (API)**

#### **A. Brain Storming**

1. What are some of the stigmas associated with accessing and utilizing MH/DD/SA services for the Asian/Pacific Islander (API) community? (The diverse composition of the API work group does not constitute, and probably should not be viewed as, a single homogeneous "community." The various ethnic groups, nationalities, cultures and backgrounds included Chinese, Filipino, Hmong, Japanese and mixed. There was an associated variety of significant cultural, language, educational and other distinctions identified. Participants ranged from recent immigrants to multi-generational Americans. Discussion centered on mental health and substance abuse issues; there was limited consideration of developmental disability matters.
  - a. Cultural beliefs, traditional preferences and community stereotyping.
  - b. Misunderstanding and/or lack of understanding of mental health and substance abuse problems and their causes.
  - c. Denial.
  - d. Family Shame.
  - e. Generational issues/conflicts tied to differing interpretations of manifestations of MH/DD/SA problems and how they should be approached.
2. What are some of the cultural, language, community and systemic barriers to accessing MH/DD/SAS for API in North Carolina?
  - a. The size and geographical variation in different API populations in North Carolina. Some are widely dispersed across the state; others are concentrated, often in relatively small numbers in a few areas.
  - b. The MH/DD/SA system's lack of knowledge of these populations, their location and their often unique MH/DD/SA educational and service needs.
  - c. The lack of MH/DD/SA system outreach to these populations
  - d. A consequent lack of trust of the MH/DD/SA system providers by users and potential users.
  - e. Inadequacies in and/or inappropriateness of MH/DD/SA assessment tools and treatment methods for these populations.
  - f. Language/translation issues in all their various dimensions, including limited English proficiency of some group members.

#### **B. Awareness**

1. What strategies would you recommend to this group to increase their awareness of consumers' cultural and linguistic needs?
  - a. State MH/DD/SAS
    - Set up a cultural competency clearinghouse to identify resources, to dialog with other systems and sources; to collect information for wide dissemination to exchange with consumers, LMEs, providers and

support groups and perform related services for special need ethnic populations.

- Develop and maintain ongoing networking and collaboration with other state systems, research in educational institutions and agencies, advocacy groups, and ethnic organizations. Don't use limited resources to "reinvent the wheel" e.g., with regard to language/translation matters, contact other jurisdictions/state/agencies with sizeable API populations (California, New York, elsewhere) that may have developed, and are willing to share, culturally appropriate/ language editions of pertinent MH/DD/SA educational materials, assessment tools and related information.
- Hold conferences/workshops/other meetings at annual or other frequencies to build on this beginning and to advance the achievement of cultural competency throughout the reformed MH/DD/SA system.
- Work with the various MH/DD/SAS licensing/certifying authorities/agencies and with colleges, universities, and other education and training institutions to develop plans and requirements that mandate the inclusion of cultural competency in the education, training, licensure and certification of MH/DD/SA professionals and paraprofessionals. This will require a long range approach together with necessary support and action by LMEs, professional organizations, advocacy groups and others.

b. Local Management Entities (LMEs)

- Identify the ethnic/minority populations in their catchment areas and become better informed on their cultures and MH/DD/SAS education and service needs.
- Develop and/or strengthen existing communication with these populations.
- Provide community outreach, education programs, seminars and workshops on MH/DD/SAS issues for these populations; engage the various ethnic groups in the development and presentation of the education programs.
- Develop a culturally competent provider network.
- Include in network provider contracts a requirement, with associated standards, for provider continuing education in cultural competency matters. (This also should be included in DMH/DD/SAS contract requirement and standards for LMEs).
- Develop, either dependently or in collaboration with DMH/DD/SAS, a monitoring process by which to measure and report.

c. Providers

- Increase/improve provider knowledge of ethnic populations and their unique or special needs.
- Hold providers accountable for compliance with the continuing education, licensing, certification and related requirements outlined above.

d. Partners

- Actively participate in the development and utilization of information systems, websites and other methods and processes to advance knowledge, understanding and utilization of the MH/DD/SA system.
- "Speak up and Speak out" regarding their service needs.
- Collaborate with other stakeholders.
- Build positive relationships with LMEs and providers.

### **C. Skills Development**

1. What are the characteristics (personal attributes, knowledge and skills) of service providers necessary to address consumers' cultural and linguistic needs?
  - a. Strong sense of social justice.
  - b. Open-mindedness.
  - c. Patience.
  - d. Willingness to learn.
  - e. Openness to change.
  - f. Communication skills in dealing with diverse client populations.
2. How would you improve the characteristics for this group to address consumers' cultural and linguistic needs?
  - a. State MH/DD/SAS
    - Establish pertinent training requirements and offer training opportunities.
    - Introduce/expand the use of external organizational and programmatic assessments/accreditations.
    - State CFAC should include a broader range of ethnic representation in membership and improve the cultural competence of the committee.
  - b. Local management Entities
    - [Same as State MH/DD/SA agency above]
  - c. Providers
    - Emphasis on continuing education in the area of cultural competence.
    - Use of training consortia and other cost effective methods for continuing education such as web-based tutorials.
  - d. Partners
    - Advocate for inclusion of cultural competence in licensing, credentialing, and certification of providers.

### **D. Recruitment (Staff & Provider Networks)**

1. What strategies need to be in place at the state and local levels to hold LMEs accountable for the recruitment and retention of a diverse workforce?
  - a. Expand the "health services corps" concept and programs to include MH/DD/SA service professions.
  - b. Develop MH/DD/SA rural health professional recruitment program to address needs of underserved areas and API and other minority populations outside urban areas.
  - c. Fund scholarships for ethnic minorities.

2. What strategies need to be in place at the academic institutions as well as in the employment organizations to ensure recruitment and retention of a diverse MH/DD/SAS workforce?
  - Redefine "minority" in academic scholarship and other educational recruitment and assistance programs to ensure the inclusion of API's. Current programs have an almost exclusive focus on African Americans and Hispanics/Latinos.

## **E. Outreach Strategies**

### **Consumer and Family Advisory Committee (CFAC)**

1. What strategies would you recommend to ensure representative membership to CFAC's based on the racial/ethnic make-up of the community served?
  - Increase the visibility of the CFAC's in the community in general and in constituent ethnic communities in particular; visits to API and other ethnic communities; encouragement of group and self nominations for CFACs from ethnic populations.
2. What are some accountability measures that can be used by the state agency and LME's to select CFAC's?
  - Conduct annual evaluations of CFAC's with regard to inclusion of API and other ethnic and racial groups in their memberships and operations.
3. What should be the guideline/criteria for selecting CFAC members?
4. How can state, LME, and provider networks increase outreach to Asian/Pacific Islander underserved populations?

## **F. Public Information/Communication**

1. Which media are effective in delivering health-related information to the Asian/Pacific Islander communities (i.e. radio, TV, newspaper, word of mouth, flyers, church bulletins etc.)?
  - a. Be cognizant of the broad range and diversity of education levels in between the various API groups when developing implementing public information and communication plans.
  - b. Recognize the strong oral cultures of some API communities.
  - c. Make heavy and focused use of the radio in communication with the groups.
  - d. Use written "flyers" for distribution to, by and through community entities, religious groups, civic and other organizations, markets and other commercial establishments frequented by API and other ethnic groups.
  - e. Arrange for multiple translations as appropriate to the populations targeted by the public information and education programs.
2. For written materials, what is the recommended reading level?
  - a. [see above note on diversity of educational levels in and between the API groups.]
  - b. Generally, aim low-Grade 4 reading level.

## **G. Assessments**

1. How to ensure that assessments and person centered plans address the cultural and linguistic needs of consumers and the diversity within racial/ethnic groups?
  - a. Include informed ethnic representation in developing/revising MH/DD/SA policies and procedures, assessment tools, diagnostic instruments and treatment modalities.
  - b. Ensure that the significance of family is not ignored or excluded in the development and implementation of person centered approaches and plans when and where culturally necessary.

### **III. HISPANIC/LATINO**

#### **A. Brain Storming**

1. What are some of the stigmas associated with accessing and utilizing MH/DD/SAS for the Hispanic/Latino community?
  - a. Perception that the family is unable to solve problems.
  - b. Fear of rejection by family, providers and employers.
  - c. Once a consumer of services, you are labeled as a consumer for "life."
2. What are some of the cultural, language, community and systemic barriers to accessing MH/DD/SAS for Hispanics/Latinos in North Carolina?
  - a. Cannot navigate the system.
  - b. Distrust of government agencies.
  - c. Latinos expect to be able to walk into a clinic without an appointment.
  - d. Lack of bilingual staff at all levels.
  - e. English only attitude.
  - f. Transportation.

#### **B. Awareness**

1. What strategies would you recommend to this group to increase their awareness of consumers' cultural and linguistic needs?
  - a. MH/DD/SAS
    - Commitment by state leadership to address and enforce cultural competency.
    - On-going monitoring of agencies that provide services.
    - Comprehensive training for all staff.
    - Visit and learn from other states on how to implement culturally competent services.
  - b. Local Management Entities (LMEs)
    - Ensure that local CFACs have Latino representation.
    - Maintain and enforce policies.
    - Use marketing strategies directed to Latinos.
    - Employ bilingual staff.
  - c. Providers
    - Adopt and enforce efforts to recruit bilingual providers.
    - Recruit and employ professionals from across the United States and Puerto Rico.
    - Make a commitment to serve the Latino community
  - d. Partners
    - Consult with bilingual competent people.



### **C. Skills Development**

1. What are the characteristics (personal attributes, knowledge and skills) of service providers necessary to address consumers' cultural and linguistic needs?
  - a. Must have a willingness to work with and in the community, outside of an office.
  - b. Master language and culture in order to provide bi-cultural service training.
2. How would you improve the characteristics for this group to address consumers' cultural and linguistic needs?
  - a. State MH/DD/SAS agency
    - Hire diverse staff members that are bi-lingual.
    - Hold providers accountable.
  - b. Local Management Entities (LMEs)
    - Never use family members to translate.
    - Provide case managers for all consumers .
    - Hold providers accountable.
  - c. Providers
    - Never use family members to translate.
    - Provide case managers for all consumers.
    - Staff of providers should reflect demographics of the communities they serve.
    - Providers should be held accountable.
  - d. Partners
    - Never use family members to translate.

### **D. Recruitment (Staff & Provider Networks)**

1. What strategies need to be in place at the state and local levels to hold LMEs accountable for the recruitment and retention of a diverse workforce?
  - a. Personnel referral system.
  - b. State should adopt a centralized system to recruit.
  - c. Reform professional certification laws and licensing.
  - d. Provide education opportunities for bi-lingual youth.
2. What strategies need to be in place at the academic institutions as well as in the employment organizations to ensure recruitment and retention of a diverse MH/DD/SAS workforce?
  - a. Flexible class scheduling.
  - b. Provide mentoring for students.
  - c. Scholarship and financial aid to help students pay for classes.
  - d. Provide tuition incentives so that older citizens can afford to go back to school.
  - e. Educate parents on benefits of college.

## **E. Outreach Strategies**

1. Consumer and Family Advisory Committees (CFACs)
  - a. What strategies would you recommend to ensure representative membership on CFACs based on the racial/ethnic make-up of the community served?
    - Recruit in areas where the population exists.
    - Educate the community on how organizations can assist.
    - Provide transportation and child care so that members can attend meetings.
    - Use Latino organizations to recruit and select.
  - b. What are some accountability measures that can be used by the state agency and LME's to select CFAC members?
    - Have CFAC report cards.
    - Maintain and report data on recruitment efforts.
    - State level CFAC that is 100% Latino.
  - c. What should be the guideline/criteria for selecting CFAC members?
    - Involvement and knowledge of culture and community.
2. How can state, LME, and provider networks increase outreach to Hispanic/Latino underserved populations?
  - a. Use radio, TV and written materials in places where Latinos frequent such as flea markets, discount stores and also supply stores.
  - b. Translate so that true meaning is communicated.

## **F. Public Information/Communication**

1. Which media are effective in delivering health-related information to the Hispanic/Latino communities (i.e. radio, TV, newspaper, word of mouth, flyers, church bulletins etc.)?
  - Flyer, word of mouth, pamphlets at the flea market, churches, state fair, music videos and local TV stations.
2. For written materials, what is the recommended reading level?
  - a. 3rd grade with lots of visuals
  - b. Simple bullet points.

## **G. Assessments**

1. How to ensure that assessments and person centered plans address the cultural and linguistic needs of consumers and the diversity within racial/ethnic groups?
  - Use research based Latino population, particularly Latino immigrants.

## Checklist to Facilitate the Development of Cultural Competence

It is important for all entities in the public system to offer services that are culturally and linguistically competent. They must first develop and then implement policies and structures to guide the provision of interpretation and translation services. In order to facilitate this process the following checklists are provided. The checklist allows the organization to perform a self-assessment and identify where gaps in the service delivery or the organization's structure and functioning are located. Once completed, the organization can begin to develop plans to close the gaps.

Does the organization or program have:

- A mission statement that articulates its principles, rationale and values for the delivery of culturally competent services?
- Policies and procedures that support a practice model which incorporates culture in the delivery of services to culturally diverse groups?
- Structures to assure the meaningful participation of consumers and communities in planning, delivery and evaluation of services?
- Process to review policy and procedures systematically to assess their relevance for the delivery of culturally competent services?
- Policies for staff recruitment, hiring, and retention that will achieve the goal of a diverse and culturally competent workforce?
- Policies and resources to support ongoing professional development and in service training for awareness, knowledge, and skills in the area of cultural competence?
- Policies that assure new staff are provided with training, technical assistance and other supports necessary to work within culturally diverse communities?
- Position descriptions and work plans that include skill sets related to cultural competence?
- Fiscal support and incentives for the improvement of cultural competence at the Division, LME and provider levels of the public system?
- Policies for and procedures to periodically review the current and emergent demographic trends for the geographic area it serves?
- Methods to identify and acquire knowledge about health beliefs and practices of emergent or new populations in the service delivery areas?

Promoting Cultural Diversity and Cultural Competency- Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs, Goode, T., 2002, NCCC, GUCDC.

## Checklist to Facilitate the Development of Linguistic Competence

Does the organization or program have:

- A mission statement that articulates its principles, rationale and values for providing linguistically competent services?
- Policies and procedures that support staff recruitment, hiring, and retention to achieve the goal of a diverse and linguistically competent staff?
- Position descriptions and work plan outcome measure that includes skill sets related to linguistic competence?
- Policies and resources to support ongoing professional development and in service training (at all levels) related to linguistic competence?
- Policies and procedures regarding the translation of patient consent forms, educational materials and other information in formats that meet the literacy needs of patients?
- Policies and procedures to evaluate the quality and appropriateness of interpretation and translation services?
- Policies and procedures to periodically evaluate consumer and personnel satisfaction with interpretation and translation services that were provided?
- Policies and resources that support community outreach initiatives to persons with limited English proficiency?
- Policies and procedures to periodically review the current and emergent demographic trends for the geographic area served in order to determine interpretation and translation services needed?

Promoting Cultural Diversity and Cultural Competency- Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs, Goode, T., 2002, NCCC, GUCDC.

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## Excerpts of a Sample Cultural Competence Self-Assessment Tool

| Target Area                | Cultural Destructiveness  | Cultural Incapacity   | Cultural Blindness  | Cultural Pre-competence  | Cultural Competence  |
|----------------------------|---|---|---|--|--|
| Community Relationship     | Maintains a board and staff that perpetuates prejudice and bias   | Displays token representation of minority populations on staff and board  | Is quiet on the issues that affect the organization's various constituents  | Recognize the need to be connected with community groups that promote certain populations and seeks to correct the situation | Displays a commitment to partnering with groups to address community needs                               |
| Organizational Environment | Prevents or demeans use of multiple languages   | Does not provide for oral or written language diversity to meet needs of population served                              | Accepts the exclusive use of English when conducting consumer sessions, regardless of consumer needs                      | Offers language training to meet needs of population   | Seeks a balanced bilingual staff/consumer ratio  |
| Service Delivery           | Prevents or demeans the use of service methods that address cultural differences  | Minimizes or tokenizes the use of service methods that address cultural differences                                     | Does not see the need to provide services that address and value differences  | Recognize the benefit of providing services that address and value differences   | Delivers services in a way that addresses and values differences   |
| Staff team Development     | Actively develops, promotions and utilizes recruitment strategies that exclude certain populations in a deliberate effort to exclude them | Utilizes recruitment strategies that exclude certain populations in an effort to maintain mainstream cultural dominance | Allows the existence of recruitment strategies that exclude certain populations and does little or nothing to change them | Questions recruitment strategies that exclude certain populations and explores ways to change them                           | Actively develops, promotes and utilizes recruitment strategies that include and attract all populations |

